

Communicable Disease Report

Hawai'i Department of Health
Communicable Disease Division

http://www.state.hi.us/doh/resource/comm_dis/cdr.html

March/April 2002

Hansen's Disease in Hawai'i: An Outpatient Perspective

Recent History

In 1969, a blue ribbon committee was established to review how Hansen's disease (HD) services were provided in the State of Hawai'i. The committee was comprised of physicians, patients, and other members of the public with an interest in HD. Until that time, HD services were provided through involuntary isolation either at Hale Mohalu Hospital in Pearl City or Kalaupapa Settlement on the island of Moloka'i. The committee recommended that since there was a medication that could treat the disease, HD services be provided on an outpatient basis. This revolutionary concept was adopted by the Department of Health (DOH) and ended a policy in place since 1865. This changed the diagnosis of HD from a traumatic life-changing event to one in which the disease was easily treated on an outpatient basis, very similar to most other communicable diseases that do not result in a major disruption in a patient's life.

The Hansen's Disease Community Program

This policy change became the foundation of the outpatient Hansen's Disease Community Program (HDCP), which was formally established in 1982. The HDCP is one of 15 regional Hansen's

disease programs nationwide. Hawai'i and Texas have unique programs in that they are statewide with direct services provided entirely through community physicians. The HDCP utilizes a network of over 80 private and community physicians to provide general and specialized HD medical care. The thirteen other regional centers in the United States (U.S.) are generally in university or teaching hospitals with services provided through centralized clinics.

Public Health Challenges

The diagnosis, care and treatment of HD is complicated by several epidemiological factors.

- The disease has a very long and variable incubation period ranging anywhere from two to 20 years but more commonly three to five years.
- The mode of transmission has not been proven. The most commonly accepted mode is thought to be through the spread of nasal secretions combined with close long-term contact.
- There is no definitive test for HD. A diagnosis of HD is usually based on clinical symptoms as well as a biopsy of suspected lesions.
- Over 95% of the population has a natural immunity to the disease. With less than 5% of the population susceptible it is surprising that the

disease has had such a long and frightful history. Even today, the history related to the stigma of the disease has proven to be a formidable barrier in the diagnosis, care and treatment of HD.

10 Year Trends

Table 1 shows the incidence of HD diagnosed in Hawai'i by place of birth for the last 11 years. Hawai'i averages approximately 20 new HD cases a year. It is diagnosed primarily in immigrants. In the last five years there has only been one Hawai'i-born case. For many of the immigrant cases, the predominant risk factor is often long-term residence in the family's country of origin. The program has traditionally diagnosed most of its cases from Filipino and Samoan-born immigrants. In 1996, this trend changed when the combined new case totals of the Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI) outnumbered the Philippine and Samoan totals. This trend has continued to the present.

For the ten-year period from 1991 to 2000, 115 of the new cases were male compared to 78 female. The sex ratio is similar to international data with ratios of male to female reported as high as 2:1 and 3:1. The numbers of

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Table 1. Incidence of Hansen's Disease in Hawai'i by Place of Birth, 1991-2001

Place of Birth	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL	
F.S.M.*	0	1	2	3	2	1	4	3	8	5	7	36	17%
R.M.I.#	0	0	0	1	2	6	8	7	4	5	10	43	20%
Philippines	15	11	14	11	12	6	10	6	8	4	7	104	48%
Samoa	2	5	0	3	1	0	1	0	2	1	0	15	7%
Hawai'i	1	2	0	1	2	1	0	1	0	0	0	8	4%
Vietnam	1	0	0	0	0	1	2	0	0	0	0	4	2%
Other**	0	1	1	2	0	0	1	2	0	0	0	7	3%
Totals	19	20	17	21	19	15	26	19	22	15	24	217	100%

* Federated States of Micronesia

Republic of the Marshall Islands

** Cambodia, China, Guam, India, Laos, Mexico, N. Marianas, Thailand, U.S. Mainland

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paucibacillary and multibacillary cases for the same period were nearly equal at 94 paucibacillary and 99 multibacillary cases. This was unique in that paucibacillary cases are generally more difficult to diagnose due to the less pronounced clinical symptoms and a number of cases that self heal which results in fewer diagnosed cases. The comparatively high paucibacillary numbers may be attributed to the HDCP's active screening program.

Passive Surveillance

New cases of HD are discovered and reported to the HDCP from different sources.

- The most productive sources are referrals through the program's network of community physicians. Over 75% (146/193) of all new HD cases were reported through these sentinel physicians for the period from 1991 to 2000. Other cases are reported by
 - DOH public health nurses,
 - self or family referrals,
 - contact investigations, and
 - immigration referrals.
- These methods are considered passive surveillance. Until 1996 they were adequate in diagnosing the existing new HD caseload within the state.


Active Surveillance

In 1996, active screening of the RMI and FSM populations residing in Hawai'i was initiated. This resulted in an increase of 31% (30/97) of new cases reported from 1996 through 2000. It was apparent in 1996 that the high rates of HD in these groups necessitated an active screening program rather than the current passive system due to cultural, language, and economic barriers to traditional "western" health care.

The HDCP utilized language-based ethnic churches to access these populations. Program nurses provided HD education to the congregations during their service and then offered skin screenings to those interested in the privacy of their homes at later times. These "faith initiatives" have been highly successful and have resulted in almost all of the congregation (50 to 80 people per site) signing up for skin screenings. The actual number of people screened usually increased as relatives and friends were also screened when program nurses were invited into the homes.

Program success with active screening is evident when paucibacillary cases and multibacillary cases are compared against the passive and active surveillance methods. From 1991 through 2000 there were 73 new paucibacillary cases vs. 90 new multibacillary cases discovered through passive surveillance. This is expected since clinical symptoms are generally more pronounced in multibacillary cases and patients are more apt to seek medical treatment. From 1996 through 2000 (active surveillance was initiated in 1996) 21 new paucibacillary cases were diagnosed as compared to nine new multibacillary cases via the active surveillance program, a reversal of what was seen with passive surveillance. The active surveillance (skin screening) method found more paucibacillary cases that may have not been detected or identified at a later date.

Communicable Disease Report

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After-hours Neighbor Island Emergency Reporting	800-479-8092	

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Earlier detection time (time to diagnosis) for active surveillance is supported in Figure 1, in which the time to diagnosis is compared with the active and passive surveillance methods. For every year since active surveillance's inception, the time to diagnosis has been substantially shorter than with passive surveillance. The active surveillance approach has diagnosed cases that may have gone undetected and for those that are diagnosed, identified those cases more quickly than by passive surveillance.

From 1991 to 2000, 369 patients were discharged from the active registry. Of those 206 (56%) completed HD treatment and a five-year observation period. Another 72 (20%) left the state prior to completing therapy and observation. Forty-two (11%) died while on therapy or observation, but HD was coincidental to their death in all of these. The remaining numbers were lost to treatment (19), non-compliant with treatment (25) or not HD categories (5).

Patterns of Pacific Islander Migration

The Micronesian (RMI, FSM and Palau) population is a highly mobile group, immigrating not only to Hawai'i but also between Hawai'i and the continental U.S. At least 7,000 Micronesians had immigrated to the state as of October 1997. This number continues to rise annually.

Over 50% of all cases leaving Hawai'i since 1991 left between 1996 and 2000 (the same period of increasing Pacific Islander cases). The program provides patient referral information to the jurisdiction to which a patient may be moving to insure continuity of care. Information from these referrals from our Micronesian population has identified California, Nevada, Arizona and Washington as migration destinations. Anecdotal information has suggested that Micronesian patients have also moved to Arkansas and Wisconsin.

Without active screening programs, these increasing immigrants in the continental U.S. will continue to incubate undiagnosed illness. The previously described barriers to health care among this group could prevent or delay diagnosis detection in their new communities. The HDCCP staff has notified the National Hansen's Disease Center, the Centers for Disease Control, and the state's Congressional delegation about this concern.

Future of Hansen's Disease in Hawai'i

The number of new cases of HD in Hawai'i is dependent on immigration patterns into the state and the rates of HD in the countries of origin. Worldwide HD is being controlled through the application of the multi-drug treatment programs. The world prevalence rate is expected to reach 1:10,000 by the year 2005; however this level will not be reached in RMI and FSM. Pockets of higher prevalence rates will remain in

other countries and may become the source of new cases entering Hawai'i.

The majority of new cases will continue to be identified and referred from practicing physicians throughout the state. However, active surveillance in migrant populations will be required for Pacific Island people unless a screening process is added to travel requirements of people entering the United States from countries under the Compact of Free Association.

Multi-drug protocols used to treat active cases of disease will probably be modified as the results of research are put into practice. The stigma related to HD in Hawai'i should decrease over time but may not, because of the continued creative use of pathos in the Arts associated with the history of HD. This history continues to be recorded anew in literature, religious history, film and the visual arts.

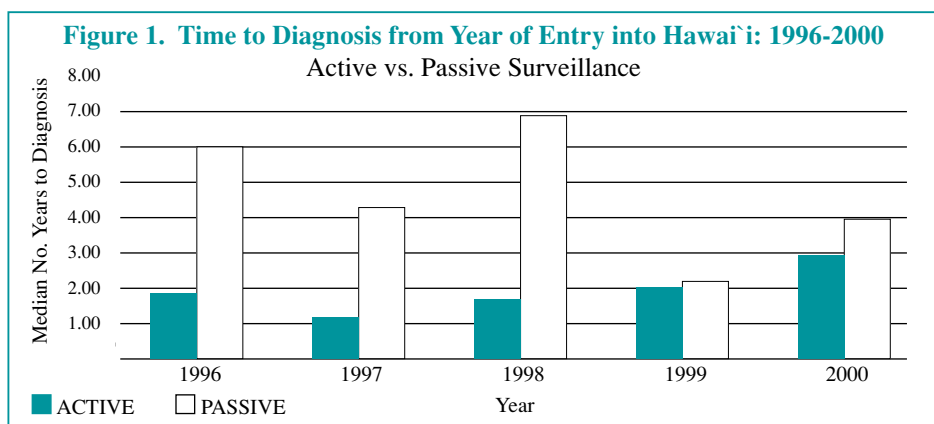
Within 20 years it is planned that Kalau-papa will primarily be a National Historical Park, where it is hoped the lives of all who lived, worked and died there will be commemorated with respect and dignity.

For more information or to report a suspected case of Hansen's Disease, please call the Hansen's Disease Branch in Honolulu at (808) 733-9831.

REFERENCES.

1. Chin J, Ed., *Control of Communicable Diseases Manual*, 17th Ed., 2000, American Public Health Association, Washington, D.C.
2. Gould KL, *Leprosy and Public Health in Hawai'i-Changing a Policy of Isolation*, 1969, Haw. Med. J.,28:(5)365-373.
3. Thangaraj RH, Yawalkar SJ, *Leprosy for Medical Practitioners and Paramedical Workers*, 1989, Ciba-Geigy Ltd., Basel, 22-24.

Submitted by Michael Maruyama, M.P.H., Planner, Hansen's Disease Branch and Mona R. Bomgaars, M.D., M.P.H., Former Chief, Hansen's Disease Branch.



Increasing Incidence of Sexually Transmitted Diseases

In 2001, the Department of Health (DOH) observed a substantial increase in incidence for syphilis, gonorrhea and chlamydia compared with previous years. The following summarizes disease trends and recommendations for diagnosis and treatment.

Syphilis

Incidence of primary and secondary syphilis increased from two in 2000 to 12 in 2001. Ten of the patients were diagnosed with primary syphilis and two with secondary syphilis. In addition to the increase in reported cases, there has also been a change in the epidemiology of the disease in Hawai'i. In previous years, cases reported primarily heterosexual contact, exposures occurring outside the state and were usually diagnosed in public clinics. In 2001, 60% (7/12) of patients with syphilis were men having sex with men (MSM) and 40% (5/12) were heterosexual. Private providers diagnosed 80% of these infections. Among the MSM, 60% (4/7) acquired syphilis in Hawai'i. Human immunodeficiency virus (HIV) status of five of the 7 cases was known: 40% (2/5) of the cases were HIV positive. 80% (4/5) of cases reporting heterosexual exposure acquired their infections outside the state.

Syphilis should be considered in the differential diagnosis of any patient with a painless lesion or chancre. Please refer to the DOH Medical Alert of March 27, 2001 for more details on syphilis or call (808) 733-9281 in Honolulu for a copy of the alert.

Gonorrhea

After years of decreasing or stable incidence, gonorrhea infections increased by 25% in 2001 over 2000 (606 vs. 484). Ciprofloxacin-resistant infections increased to 21% of cases in 2001 from 10.4% of cases in 2000. Because fluoroquinolone-resistant gonorrhea is now

widely distributed throughout Hawai'i, patients diagnosed with gonorrhea in the state should not be treated with fluoroquinolones.

Cefixime and ceftriaxone are the recommended drugs of choice for the treatment of gonorrhea in Hawai'i. Since patients infected with gonorrhea are often co-infected with chlamydia, the 1998 Guidelines for Treatment of Sexually Transmitted Diseases states "patients treated for gonococcal infections should also be treated routinely with a regimen effective against uncomplicated genital *C. trachomatis* infection."

Several gonococcal isolates with decreased susceptibility to cefixime were also identified in the state in 2001. If a patient has traveled to Asia and/or the Pacific and a clinician suspects gonorrhea infection or treatment failure, obtaining a specimen for culture and requesting antibiotic sensitivity testing is highly recommended.

Chlamydia

Chlamydia incidence has been rising in Hawai'i since 1997. The incidence rate has increased from 151/100,000 population in 1997 to 333/100,000 population in 2001. Most cases of chlamydia in the state are reported in 15-24 year old females. This may reflect the extensive chlamydia screening conducted in family planning clinics. Due to the high rates of asymptomatic chlamydia infections in women, the DOH recommends routine screening for all sexually active females 25 years of age or younger at the first visit. Women in this age group should subsequently be screened annually and whenever the patient reports having a new sex partner.

The DOH asks your assistance in providing prompt diagnosis, treatment and reporting of syphilis, gonorrhea and chlamydia. We also request you routine-

ly ask the names and locating information of the patients' sex partners for medical management. DOH disease intervention specialists with the STD/HIV Prevention Program are available to assist with patient and partner counseling and referral. Patients should also be counseled regarding the risks of unprotected sex. All patients diagnosed with an STD should be encouraged to undergo testing for HIV infection. STD infections increase the risk for HIV acquisition and transmission.

Recommended Screening

Gonorrhea and chlamydia screening is recommended for sexually active females with one or more of the following risk factors:

- The patient reports a new sex partner or multiple sex partners.
- The patient is less than 25 years of age,
- The patient has a mucopurulent cervicitis on examination, and/or
- The patient has a prior history of a sexually transmitted infection.

STD/AIDS Prevention Program Services

The DOH provides free counseling, education, testing and referral services for STDs and HIV/AIDS.

STD Services

For consultation, testing and referrals, please contact the following:

- On O`ahu, the Diamond Head Health Center at (808) 733-9281,
- On Hawai'i, Chester Wakida at (808) 933-0912,
- On Maui, Kris Mills at (808) 984-8313, and
- On Kaua'i, Jo Manea at (808) 241-3563.

2001 Immunization Provider Site Visits

HIV/AIDS Services

For HIV/AIDS reporting, please call (808) 733-9010 in Honolulu.

For educational information, materials and presentations, please contact the following:

- On O`ahu, Carl Bayaca or Loia Fiaui at (808) 733-9281,
- On Hawai`i, Jesse Wells at (808) 974-4245,
- On Maui, Mary Santa Maria at (808) 984-2105, and
- On Kaua`i, Malama Pono at (808) 246-9577.

For confidential counseling and testing, please call the following:

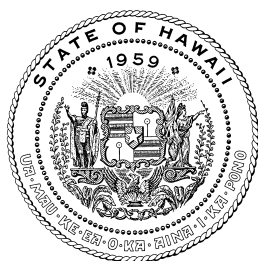
- On O`ahu, (808) 733-9280,
- On East Hawai`i, (808) 974-4247,
- On West Hawai`i, (808) 322-9705,
- On Maui, (808) 984-2129,
- On Moloka`i, (808) 553-3145,
- On Lana`i, (808) 565-6411, and
- On Kaua`i, (808) 246-9577.

For further questions or information, please contact Roy Ohye or Venie Lee at the STD Prevention Program Office in Honolulu at (808) 733-9281.

REFERENCE.

Fluoroquinolone-Resistance in *Neisseria gonorrhoeae*, Hawai`i, 1999, and decreased Susceptibility to Azithromycin in *N. gonorrhoeae*, Missouri, 1999. MMWR 2000;49:833-837.

Submitted by Venie Lee, Epidemiological Specialist, STD Prevention Program, STD/AIDS Prevention Branch.



Introduction

In January 2001, the Hawai`i Immunization Program (HIP) began conducting federally mandated Vaccines for Children/Assessment, Feedback, Incentive, Exchange (VFC/AFIX) visits in its public and private VFC provider sites. The purposes of the VFC/AFIX visits were to

- evaluate and assess a provider's compliance with VFC procedures,
- ensure providers understand and practice current state and federal program policies and recommendations,
- provide an opportunity for feedback, and
- perform a screening of a provider's immunization rates.

Utilizing the Centers for Disease Control and Prevention's (CDC's) required minimum criteria, a provider's VFC procedures, storage and handling of vaccines, and use of Vaccine Information Statements (VIS) were reviewed. A number of vaccine practices and policies were discussed with the office manager or nurse. These discussions included VFC eligibility screening procedures, use of VFC vaccines, vaccine accountability, provider recall mechanisms, and use of information statements. The VISs on site were reviewed to assure that the most recently published version was being provided to parents/guardians of children receiving immunizations. Also included in the site visit was a review of vaccine storage and handling practices, such as maintenance of the cold chain and proper refrigerator/freezer temperatures, location of vaccines in the refrigerator/freezer, rotation of vaccines with removal of any expired vaccines and proper identification and separation of publicly procured vaccine from privately purchased vaccine. This review was conducted at the site's refrigerator/freezer with the individual in charge of the storage and management of the vaccines.

To maximize the usefulness of these office visits, HIP staff offered providers as-

sistance with monitoring and improving their immunization levels (AFIX portion). The screening of immunization levels, which utilizes a combination of Lot Quality Assurance (LQA) and Clinic Assessment Software Application (CASA), requires 30 charts of patients in the age range of 19 to 35 months who have made at least two visits to the practice and have no documentation in the chart of having moved or gone elsewhere for services. Fully immunized status is defined as having received four doses of DTaP, three Polio, one MMR, three Hib, and three Hepatitis B by 19 to 35 months of age. Hawaii's VFC Program set an 80% threshold level, as a goal for this immunization screening.

Following the site visit, a brief summary of the findings was discussed with the physician and/or office personnel. In addition, a written report of the findings and the HIP's recommendations was mailed to the provider two to three weeks after the visit.

Site Visit Findings

In 2001, 112 VFC provider sites were visited. Of these, 99 were private sites and 13 were public sites (Public Health Nursing Clinics and Community Health Centers). An AFIX assessment (immunization screening) was conducted in 68 of the 112 sites. Although 99% of the 112 sites were open to an AFIX assessment, in 43 offices this assessment could not be completed because these providers did not have the 30 charts within the specified age range. Of the 68 sites that received an AFIX assessment, 36% achieved a threshold level of 80% or better.

Some of the notable findings from the provider site visits included:

Vaccine management

- No emergency vaccine storage plan,
- Vaccines stored outside of recom-

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Global Pacific Health Conference

The first Global Public Health Conference will be held in Honolulu at the Hawai'i Convention Center on June 12-13, 2002. The conference is being sponsored by the Hawai'i Public Health Association (HPHA) in association with the American Public Health Association (APHA), Hawai'i Primary Care Association, University of Hawai'i (U.H.) Globalization Research Center, the U.H. John A. Burns School of Medicine, Region IX Office of Public Health Services - U.S. Department of Health and Human Services, the Hawai'i Department of Health, Hawai'i Medical Services Association Foundation, Cancer Research Center of Hawai'i, the Hawai'i Outcomes Institute and Diagnostic Laboratory Services, Inc.

Conference objectives include to:

- Promote public health dialogue and collaborative action on global public health issues,
- Support broader policy, infrastructure

and leadership for the Pacific public health community,

- Identify public health resources for the Pacific,
- Offer continuing education and professional public health training and educational opportunities for the Pacific, and
- Develop consensus statements that will help guide Pacific Island public health policy.

The conference will consist of plenary speakers, contributed paper sessions, poster sessions, as well as a series of roundtable discussion groups. It will also include site visits to public health locations throughout the state.

Plenary speakers confirmed to date include:

- Laurie Garrett, medical and science writer for *Newsday*, and author of "Betrayal of Trust: The Collapse of

Global Public Health,"

- Dr. Jay Glasser, APHA President-elect,
- Dr. Sitaleki Finau, Editor of the *Journal of Community Health and Clinical Medicine for the Pacific*, and Professor of Public Health at the Fiji School of Public Health, and
- An additional Hawai'i-Pacific speaker to be announced.

Advance registration is \$220.00 for HPHA/APHA members, \$245.00 for non-HPHA/APHA members, \$270.00 for members on-site registration, \$295.00 for non-members on-site registration.

For more information, please contact the Hawai'i Public Health Association website at: www.hawaiipublichealth.org.

Submitted by David M. Sasaki, D.V.M., M.P.H., Veterinary Medical Officer, Epidemiology Branch.

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mended temperature (i.e. varicella vaccine stored in the refrigerator, refrigerators/freezers not maintaining the recommended temperature range),

- Use of dorm-style refrigerator/freezer units,
- VFC and private stock vaccine not identified and/or not physically separated,
- Vaccines not rotated, resulting in expired vaccines, and
- Expired vaccines mixed with vaccines still in date.

Vaccine accountability

- Vaccine Administration Visit Record (VAVR) forms not completed and/or submitted, and
- Incorrect or incomplete VAVR forms.

Immunization record documentation

- Missing VIS publication date (Documentation of the VIS publication date is required by federal law),
- Immunizations received elsewhere

not included on immunization record (i.e. birth dose of hepatitis B vaccine), and

- Pneumococcal conjugate vaccine recorded as "pneumococcal" (no differentiation between conjugate and polysaccharide).

Inappropriate use of VFC vaccine

- No eligibility screening performed prior to the administration of VFC vaccine, and
- VFC vaccine administered to a non-VFC eligible child.

Site visits will continue in 2002. It is important to remember that these site visits are an opportunity to assist providers in complying with state and federal program requirements, to offer an avenue for feedback, and to develop a working partnership between the HIP and VFC providers to increase immunization rates throughout the State.

Submitted by Loriann M. Kanno, Dpharm, Hawai'i Immunization Program, Epidemiology Branch.

Dengue Fever Update

As of April 8, 2002 there have been an additional seven cases of autochthonous dengue fever cases diagnosed in Hawai'i since publication of the January/February issue of the *Communicable Disease Report*. Most of the reported cases have been patients whose onsets occurred in 2001. Since the previous report, there has been one new case, whose onset was in the week beginning February 3, 2002.

There have been five imported cases diagnosed with symptom onsets in 2002. Their exposures occurred in American Samoa (2), the Society Islands (2) and Easter Island.

For continuing, current reports of the outbreak, please see the Department of Health website at: http://www.state.hi.us/doh/dengue/update_report.html.

Submitted by David M. Sasaki, D.V.M., M.P.H., Veterinary Medical Officer.

2001 Surveillance Summary

The following are provisional 2001 state and county communicable disease totals by date of report and incidence rate (cases/100,000 population). The diseases listed correspond to those in the Communicable Disease Surveillance graph that appears on page 9. Incidence rates are in **bold** print. Changes in state case totals from 2000 are also listed.

Disease	2001 Cases and Incidence Rates by State and County										
	State	Change@	Rate	Honolulu	Rate	Hawaii	Rate	Maui	Rate	Kauai	Rate
AIDS	138	28	11.6	60	6.8	43	28.9	22	17.2	13	22.2
Campylobacteriosis	756	-82	63.8	554	63.2	89	59.9	78	60.8	35	59.9
Chlamydia	4035	923	333.0	3471	396.2	244	164.1	239	186.4	70	119.7
Giardiasis	114	8	9.4	81	9.2	20	13.5	7	7.8	3	5.1
Gonorrhea	604	141	49.9	553	63.1	15	10.1	28	21.8	4	6.8
Hepatitis A	17	-5	1.4	14	1.6	1	0.7	1	0.8	1	1.7
Salmonellosis	358	122	29.5	280	32.0	40	26.9	20	25.0	12	10.3
Tuberculosis	148	12	12.2	122	13.9	15	5.4	16	10.1	5	8.6
Ciguatera Poisoning	58	20	4.8	11	1.3	7	4.7	13	10.1	27	46.2
Dengue Fever,											
Autochthonous	113	113	9.3	24	2.7	0		85	66.3	4	6.8
Imported#	36	35	3.0	23	2.6	4	2.7	5	3.9	2	3.4
Hansen's Disease	24	8	2.0	16	1.8	6	4.0	2	1.6	0	
Acute Hepatitis B	22	8	1.8	17	1.9	1	0.7	1	0.8	0	
Leptospirosis*	33	-3	2.7	7	0.8	12	8.1	1	0.8	12	20.5
Measles	8	4	0.7	7	0.8	0		0		1	1.7
Pertussis	42	10	3.5	31	3.5	6	4.0	3	2.3	2	3.4
Rubella	2	2	0.2	1	0.1	0		1	0.8	0	
Syphilis, Primary and Secondary	12	8	1.0	10	1.1	2	1.3	0		0	

@ = Change in the numbers of cases from 2000.

- Includes two non-residents diagnosed in transit.

* Incomplete

Feline AIDS Vaccine Approved

EDITOR'S NOTE: *Feline immunodeficiency virus produces a disease in cats similar to AIDS in humans. It does not infect or cause disease in humans.*

The first vaccine for feline immunodeficiency virus (FIV) was approved for commercial production and veterinary use by the U.S. Department of Agriculture. The patented vaccine for this disease has been licensed for manufacture to Fort Dodge Animal health, a division of Wyeth. The vaccine should be available to veterinarians this summer. This vaccine offers the first effective protection for cats against this often fatal disease.

The Disease

FIV is transmitted from cat to cat mainly through bite wounds, because the virus is present in high levels in saliva. Like human AIDS, the virus attacks the body's immune system, making the animal susceptible to diseases and infections that usually would have little effect on a normal cat.

Cats infected with FIV may remain healthy for 5-10 years before symptoms such as diarrhea, weight loss, fever, swollen lymph nodes, and chronic infections appear. Infected cats become lifelong carriers of the virus.

It is estimated that between two and 25 percent of cats worldwide are infected with the virus. Infection rates are highest in Japan and Australia, and lowest in the United States and Europe. Outdoor roaming cats, older animals, and cats with chronic ill-health are more likely to be infected.

The Vaccine

The new vaccine is made from an inactivated virus and is composed of two different virus strains. Sixty-seven percent of cats receiving 3 doses were protected

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2001 Index of Articles

The following articles were published in 2001 in the Communicable Disease Report. They are listed alphabetically by subject, with the date of publication and the Branch/program that authored the article.

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- Rash Illnesses, Hawai'i Providers Requested to be on Alert for (Mar-Apr) (7)
- Scombroid Fish Poisoning: A Review (Nov-Dec) (2)
- STD/AIDS Prevention Branch Staff Members, New (Mar-Apr) (5)
- Surveillance Summary, 2000 (Jan-Feb) (2)
- Syphilis Cases in Hawai'i, Recent Increase of (Mar-Apr) (5)
- Teen Vax Project: Free Vaccines for Youth (Mar-Apr) (7)
- Tetanus and Diphtheria Vaccine Storage (Mar-Apr) (7)
- Vaccine, Emergency, Storage Plans (May-Jun) (7)
- Vaccine-Preventable Diseases, Epidemiology and Prevention of, Registration (Jan-Feb) (7)
- Vegetables, Do you wash your? Kaua'i Farmers Survey. (Jan-Feb) (11)

Branches/Programs Submitting Articles and the Number of Articles Submitted

- (1) Epidemiology Branch - Bioterrorism Preparedness and Response Section (1)
- (2) Epidemiology Branch - Zoonoses (11)
- (3) Communicable Disease Division (1)
- (4) Emergency Medical Services Systems Branch (1)
- (5) STD/AIDS Prevention Branch (3)
- (6) Epidemiology Branch - Investigation Section (2)
- (7) Epidemiology Branch - Hawai'i Immunization Program (10)
- (8) Epidemiology Branch - Hepatitis Control Section (1)
- (9) Office of the Director (1)
- (10) Hansen's Disease Branch (2)
- (11) Kaua'i District Health Office - Epidemiology (1)

Submitted by David M. Sasaki, D.V.M., M.P.H., Veterinary Medical Officer, Epidemiology Branch.

Feline AIDS Vaccine

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from a challenge one year later, while 74% of non-vaccinated cats became infected with FIV. Studies indicated that the vaccine provides protection against FIV for at least 12 months.

Hope for Humans

The success of this vaccine against immunodeficiency virus in another species offers hope that eventually a vaccine will be developed that will effectively protect against AIDS in humans.

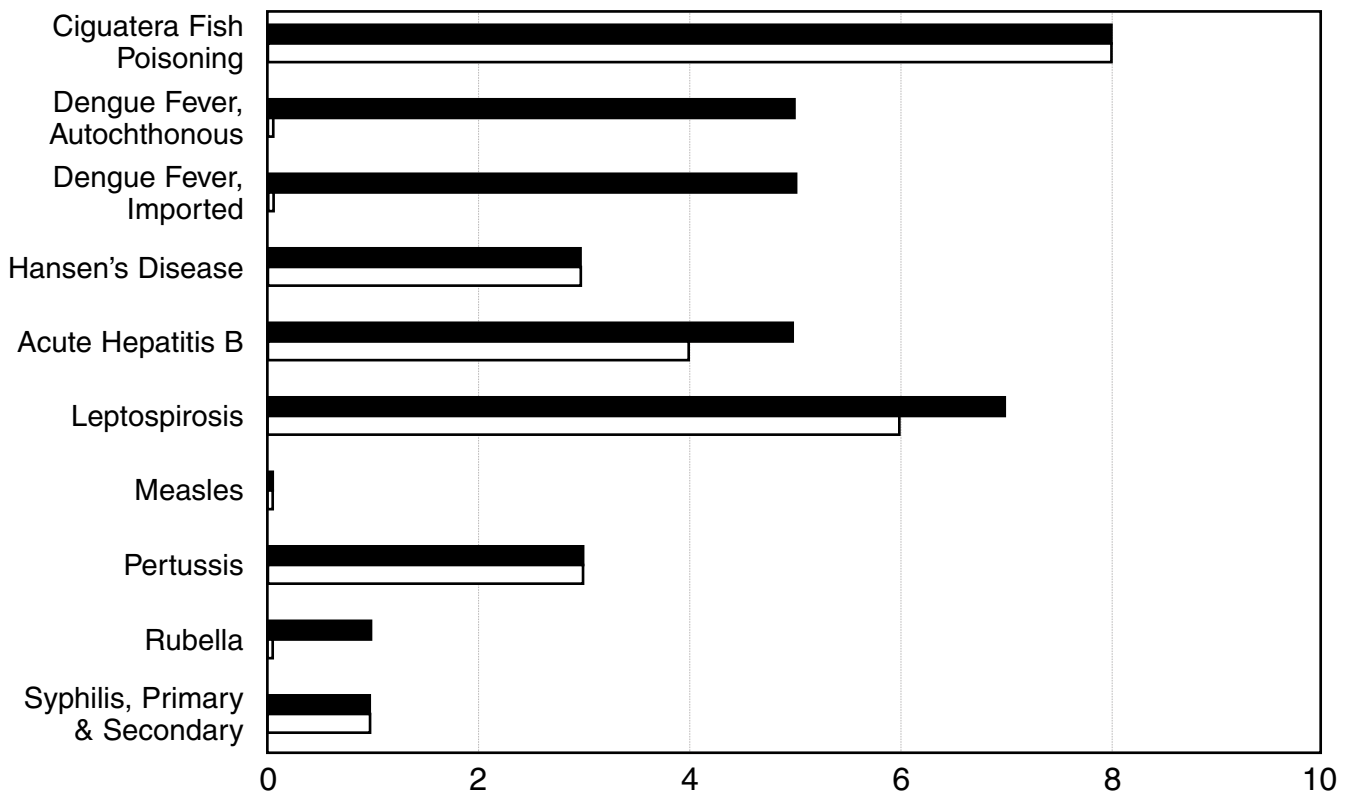
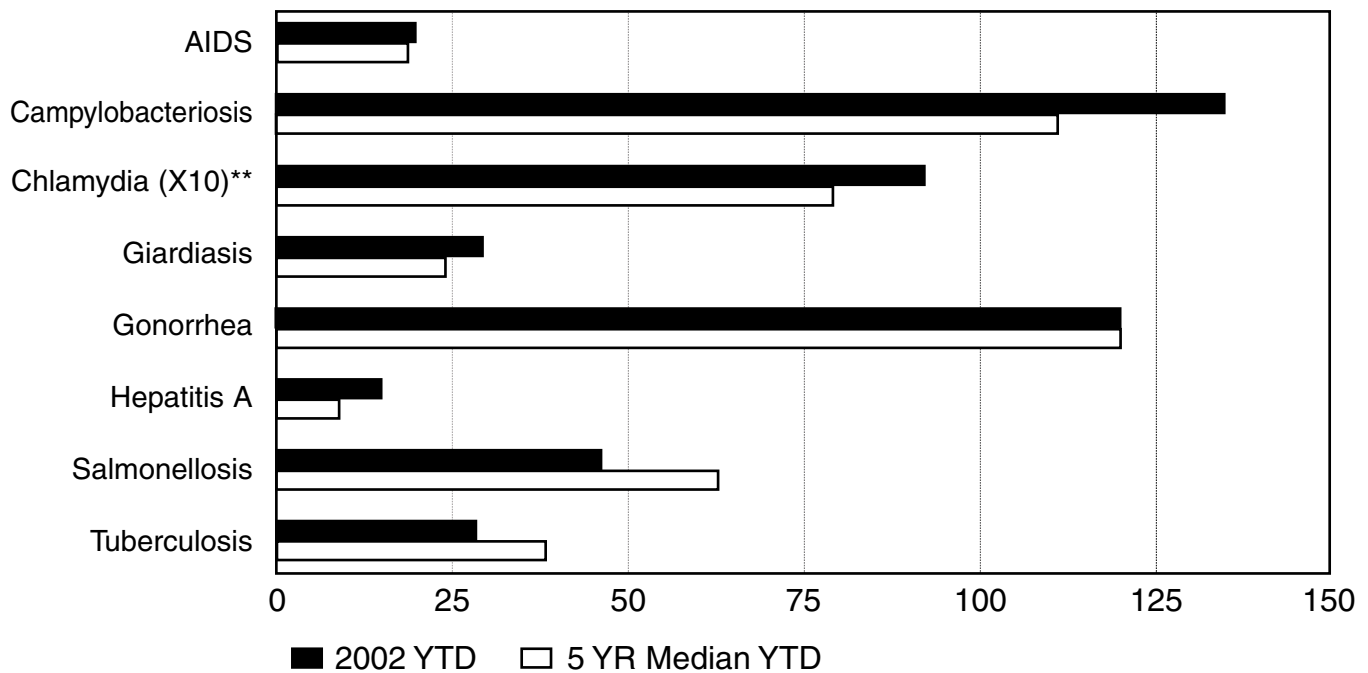
REFERENCE.

Feline Immunodeficiency Virus: Vaccine. ProMED-mail electronic mail posting, March 25, 2002.

Submitted by David M. Sasaki, D.V.M., M.P.H., Veterinary Medical Officer.

Communicable Disease Surveillance

Selected Diseases by Date of Report*
Hawai'i, 2002 Year-to-date Through March



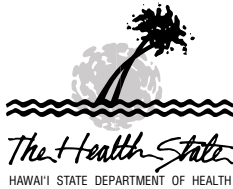
* These data do not agree with tables using date of onset or date of diagnosis.

**The number of cases graphed represent 10% of the total number reported.

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Communicable Disease Report

Paul V. Effler, M.D., M.P.H., Chief, Communicable Disease Division

March/April 2002

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- ◆ *Hansen's Disease in Hawai'i: An Outpatient Perspective*
- ◆ *Increasing Incidence of Sexually-Transmitted Diseases*
- ◆ *2001 Immunization Provider Site Visits*
- ◆ *Global Pacific Health Conference*
- ◆ *Dengue Fever Update*
- ◆ *2001 Surveillance Summary*
- ◆ *Feline AIDS Vaccine Approved*
- ◆ *2001 Index of Articles*